ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/ Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFITS PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policy Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policy Holder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICY HOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Subscriber/Policy Holder Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Policy Holder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Policy Holder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

35: COB Information
T=Payment
PR:01=Patient Responsibility
CO:45 = Contractual Write

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33.Total Fee	

35. Remarks
T:400 PR:01:100 CO:45.50

AUTHORIZATIONS

36. I have been informed ponsible for all charges for dental service prohibited by law, or the treating dentist or dent biting all or a portion of such charges. To the exte my protected health information to carry out pa

X_____
Patient/Guardian signature

37. I hereby authorize and me, directly to the below named dentist or dental entity.

X_____
Subscriber signature

48: Name and Service Location of Provider submitting the bill (If NPI is not a one to one match to Medicaid Contract Number, system will look at Service Address to match the Medicaid Contract Address.

BILLING DENTIST OR D ty is not submitting claim on behalf of the patie

48. Name, Address, City, State, Zip Code

49: Billing NPI

49. NPI	50. License Number	51. SSN or TIN
1234567891		
( ) –	52A. Additional Provider ID 1D54622346100	

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other	39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining	43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) / 44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple pleted.

Date

	55. License Number
, Zip Code	56A. Provider Specialty Code

52A: Medicaid ID number with a 1D Qualifier

57. Phone Number ( ) –	58. Additional Provider ID